Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

Last Updated: 03/09/2022

Enhanced Ambulatory Patient Group (EAPG) for Ambulatory Surgery Centers

The purpose of this memo is to inform you of a new reimbursement methodology for Ambulatory Surgery Centers (ASC), effective April 5, 2010. Currently, Medicaid reimburses ASCs based on Medicare assignments of procedure codes to one of nine ASC groups in effect prior to January 2007. The Department of Medical Assistance Services (DMAS) continues to use this methodology for Medicaid even though Medicare implemented a new reimbursement methodology in January 2007. For new ASC procedure codes covered after January 1, 2008 that cannot be assigned to one of the existing nine ASC groups, primarily office- based procedures, DMAS pays a percentage of the Medicare Ambulatory Payment Classification (APC) rate for the effective date of each procedure.

Effective on claims with dates of service on or after April 5, 2010, DMAS will reimburse ASCs using a new Enhanced Ambulatory Patient Group (EAPG) methodology developed and licensed by 3M. DMAS' new methodology will no longer be dependent on the Medicare methodology. The EAPG methodology defines Enhanced Ambulatory Patient Groups (EAPGs) as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by ASCs. **This will be a total all-inclusive reimbursement.** Each group is assigned an EAPG-relative weight that reflects the average cost for each EAPG compared to the average cost for all other EAPGs. A base rate is determined by dividing total statewide reimbursement for ASC services by the total number of EAPG visits for ASC services during a recent base period. The total allowable operating rate per visit is determined by multiplying the base rate times the EAPG relative weight.

Total expenditures under the new methodology should be budget neutral or the same as total expenditures under the old methodology. The base rate will be recalculated every three years to maintain budget neutrality. The EAPG relative weights implemented will be the weights determined and published periodically by DMAS. The EAPG weights and the base rate are available on the DMAS web site at www.dmas.virginia.gov. Click on Provider Services, Rate Setting Information, Outpatient Facility Rates, Ambulatory Surgery Center. The weights will be updated at least every three years in concert with calculation of the Budget Neutrality Factor for ASCs. New outpatient procedures and new relative weights shall be added as necessary between the scheduled weight and rate updates. Providers will be notified in advance of updates to the weights and base rate.

Claim Billing Information

You will not have to change your current billing practices. Claims will continue to be billed on the CMS-1500 (08-05) claim form as you currently do. The Final EAPG will print on your remittance advice.

Reconsideration /Appeals

Providers may request reconsideration of actions taken by an EAPG edit via email (EAPG@dmas.virginia.gov) or by submitting a written request with additional documentation to the following mailing address:

Payment Processing
Unit, EAPG Division of
Program Operations

Department of Medical
Assistance Services 600 East
Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the EAPG adjudication for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional payment. Requests received without additional documentation or after the 30-day limit will not be considered.

Provider Appeals

If the adverse decision is upheld, the provider may appeal the reconsideration decision.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level appeal with the DMAS Appeals Division within 30 days

of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division

Department of Medical
Assistance Services 600 East
Broad Street, 11th Floor
Richmond, VA 23219

If the provider is dissatisfied with the first-level appeal decision, the provider may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia,* § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division

Department of Medical
Assistance Services 600 East
Broad Street, 11th Floor
Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the recipient (client) for covered services that have been provided and subsequently denied by DMAS.

EDIT Information:

The following edits will be used for EAPG processing:

Adjustment Reason Code	Edit/ESC	EOB for Generated Claim	Description	HIPAA Codes	Pend
1008	1267	1452	EAPG Same significant procedure consolidation.	CO/97/M15	P2/454
1009	1268	1469	EAPG Clinical significant procedure consolidation.	CO/97/M15	P2/454
1014	1269	329	EAPG Multiple significant procedure discounting.	CO/151/M86	P2/454
1015	1315	331	EAPG Repeat ancillary procedure discounting.	CO/151/M86	P2/455
1016	1334	332	EAPG Bilateral discounting.	CO/151/M86	P2/454
1017	1451	333	EAPG Terminated procedure discounting.	CO/97/N56	P2/454
		335	EAPG Full Payment	CO/45/MA125	
		336	Consolidation/Packaged	CO/45/M15	

EAPG Examples 3M Version 3.4

Procedure Code Billed	Description	Modifier(s)	Units	Current DMAS Payment	Final EAPG	EAPG Payment
26412	Repair, Extensor Tendon Hand		1	$426.05	34- Level II Hand Procedures	$656.45
26412	Repair, Extensor Tendon Hand	50	2	$639.07	34- Level II Hand Procedures	$656.45
41899	Unlisted Procedure, Dentoalveolar Structures		1	$524.83	252 Level I Facial and ENT Procedures	$320.16
12041	Layer Closure of wounds of Neck, Hands or Feet	SG	1	$371.52	12 Level I Skin Repair	$37.68

To contact 3M for more information about EAPG software, please call 800-367-2447 or click the link below to submit your contact info to 3M and the correct representative will contact you:

http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Who_We_Are/Contact

_Us/Email/.

Managed Care Organizations

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCOs). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may reimburse differently than as described for Medicaid or FAMIS fee-for-service individuals. For more information, please contact the MCO directly.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices will no longer be printed and mailed free of charge. Duplicate remittance advices

will be processed and sent via secure email. A processing fee for generating duplicate paper remittance advices has been applied to paper requests, effective July 1, 2009.

ALTERNATE METHODS TO LOOK UP INFORMATION

As of August 1, 2009, DMAS authorized users now have the additional capability to look up service limits by entering a procedure code with or without a modifier. Any procedure code entered must be part of a current service limit edit to obtain any results. The service limit information returned pertains to all procedure codes used in that edit and will not be limited to the one procedure code that is entered. This is designed to enhance the current ability to request service limits by Service Type, e.g., substance abuse, home health, etc. Please refer to the appropriate Provider Manual for the specific service limit policies.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com.

The MediCall voice response system will provide the same information and can be accessed by calling 1-800- 884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and

Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-enewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.